STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121903-001**

McLaren Health Plan
Respondent

Issued and entered
this 10th day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On June 15, 2011, XXXXX, authorized representative of his patient XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner receives health benefits under a certificate of coverage issued by McLaren Health Plan, a health maintenance organization. The Commissioner notified McLaren of the request for external review and requested that McLaren submit the information used in making its final adverse determination. The Commissioner received McLaren's response on June 22, 2011. After a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The issue in this external review can be decided by an analysis of the Petitioner's certificate of coverage, the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner's certificate of coverage has two benefit levels. Under the certificate's Option A, medical care is coordinated by the member's primary care physician who either treats the member or provides referrals for specialty care, subject to approval by McLaren. Option A

care is provided at the lowest out-of-pocket expense to the member. The certificate's Option B benefit level does not require McLaren-approved referrals for specialty care. However, care obtained from a non-participating provider may result in significant out-of-pocket expenses to members.

On September 21 and October 14, 2010,[1] the Petitioner had office visits with Dr. XXXXX of the Department of XXXXX at the University of Michigan (U of M). Dr. XXXXX and the U of M are not part of McLaren's network of providers. No referral was issued by McLaren for this care. McLaren provided coverage at the Option B level of benefits.

Dr. XXXXX, Petitioner's physician, later submitted a request for retroactive authorization for coverage at the Option A level of benefits. McLaren denied the request for coverage at the Option A benefit level because the care was not pre-authorized and because care was available from participating providers.

The Petitioner appealed McLaren's denial of payment at the Option A benefits level. At the conclusion of McLaren's internal grievance process, the Petitioner received McLaren's final adverse determination letter dated May 24, 2011.

III. ISSUE

Did McLaren properly deny the Petitioner Option A coverage for her medical care of September 21 and October 14, 2010?

IV. ANALYSIS

Petitioner's Argument

The Petitioner wants the September 21 and October 14, 2010, dates of service reprocessed at the Option A benefit level. The Petitioner herself did not submit an explanation as to why she believed McLaren's claims processing was not correct. The Petitioner's representative did submit a copy of an (undated) letter to McLaren which stated:

[1] In addition to the dates of services of September 21 and October 14, 2010, the Petitioner's external review request form indicates she may be seeking coverage for several other procedures which occurred in 2010 (June 4, July 6, October 11, October 14, and October 25). Medical care on those dates was not addressed in the final adverse determination which is the subject of this review. Before the Commissioner may address a denial of coverage, the covered individual must have completed the insurer's internal grievance process. This review only addresses the September 21 and October 14, 2010, dates of service because those are the only dates of service which were considered in McLaren's internal grievance process.

> To whom it may concern:
>
> I received your recent correspondence on my patient denying care on the following dates of service: *09/21/2010* **and** *10/14/2011* as not being medically necessary with Dr. XXXXX at U of M department of XXXXX. While I understand the need to contain healthcare costs, it should not be at the expense of patients and their need to obtain quality care.
>
> My clinical documentation is clear and demonstrates medical necessity. This patient experienced Internal Carotid Stenosis that required more intensive treatment and care. The patient's condition is demonstrated by the following objective findings: [the Petitioner] is a 50 year old female who most likely has suffered a carotid dissection leading to cervical left ICA occlusion. If this additional information does not allow reconsideration and/or approval for dates of services listed above, I would like to know what McLaren Health Plan's definition of medical necessity.
>
> I feel that it is your responsibility to the patient to provide reasonable, fair and necessary care under the terms of the policy. Your personal attention in reviewing this situation is appreciated. I have acted in good faith to provide this care and to provide you with this information, and in turn I request that you will consider this information and provide me with your response within the next 30 days.

Respondent's Argument

In its final adverse determination of May 24, 2011, McLaren explained its denial of coverage:

> The McLaren Health Plan Appeals Committee has carefully reviewed your appeal request for payment of services to Dr. XXXXX and the University of Michigan at the Option A benefit level . . .
>
> After reviewing the information provided, it has been determined that the appeal request for payment of these services is not approved. Dr. XXXXX and the University of Michigan are not contracted providers for the delivery of your patient's medical benefits. As stated in the McLaren Health Plan Certificate of Coverage pages 23 and 24 . . . if the member chooses to receive services from a non-participating provider they may incur costs higher than those received from a participating provider.

Commissioner's Review

The certificate of coverage explains the Option A and Option B levels of benefits:

> **8.01 Option A Benefits**
>
> Option A works like a traditional HMO. Under this option, your PCP coordinates your medical care and issues referrals for specialty care, when needed. All of your health care is provided for the lowest Out-of-Pocket expense to you.
>
> In order to receive Option A Benefits, your PCP must arrange any care not provided by him/her by issuing a referral, when needed. It is important to obtain a referral from your PCP before your receive specialty care. If no referral is issued, the service is paid under the Option B Benefit and you have more Out-of-Pocket costs.
>
> **8.02 Option B Benefits**
>
> Option B Benefits allows you to self-refer, meaning a referral from a PCP is not required. In addition, you can choose to receive services from any doctor or hospital, whether the provider participates with MHP or not. In exchange for this flexibility, the Out-of-Pocket expenses are higher than under Option A.
>
> If you choose to receive services from a non-participating provider, you may incur costs higher than those received from a participating provider, even if the services are identical. In some cases, you may have to pay the price difference between the cost of the services and what MHP pays a participating provider for the service. These costs can be significant, which is why it is important to understand your liability when using a non-participating provider.

The certificate provides that care from non-participating providers is payable under the Option B benefits. In Petitioner's case, there is no dispute that Petitioner received services from non-participating providers and McLaren paid at the Option B level.

The Commissioner finds McLaren's denial of coverage at the Option A benefit level for the care from non-participating providers is consistent with the terms and conditions of the Petitioner's certificate of coverage.

V. ORDER

The Commissioner upholds McLaren Health Plan's final adverse determination of May 24, 2011. McLaren is not required to provide coverage at the Option A benefit level for the dates of service of September 21 and October 14, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner